STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WISCONSIN

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
				The charge for each service was computed by reviewing the average amount billed for the service in a recent period and comparing that average charge to the maximum allowable under 42 CFR 447.54. If there is any variation on average charges for specific procedures within a service category, the lowest maximum allowable was chosen (e.g., $.50 for OTC drugs) for the entire category.
AMBULATORY SURGERY SERVICES			X	$3.00 per surgery.
AUDIOLOGICAL TESTING			X	$1.00 per procedure.

OFFICIAL

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
CHIROPRACTIC SERVICES				
Office Visits/Manipulations			X	$1.00 per procedure.
Laboratory			X	$1.00 per procedure.
Radiology			X	$3.00 per procedure.
COMMUNITY CARE ORGANIZATION (CCO)			X	$3.00 per month.
DAY TREATMENT SERVICES			X	$.50 per day. (Outpatient psychotherapy services in excess of 15 hours or $500.00 of accumulated services per recipient per year rate exempt from copayment.)
DENTAL SERVICES INCLUDING ORTHODONTIA			X	$0.50 - $3.00 per service depending on the price of the service.

OFFICIAL

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
DRUGS AND DISPOSABLE MEDICAL SUPPLIES				
Legend Drugs, OTC's, Disposable Medical Supplies (Except Family Planning Items)			X	$1.00 per each new and refill legend drug prescription up to $5.00 per pharmacy per month. $0.50 per item for each new and refill OTC drug prescription and disposable medical supply. (No monthly limit for OTCs or disposable medical supplies .)
DURABLE MEDICAL EQUIPMENT				
Durable Medical Equipment Purchase			X	Between $0.50 and $3.00 depending on the price of the item.
EPSDT (HealthCheck)			X	$1.00 per screening for recipients age 18 and over.
GLASSES				
Dispensing Complete Appliance			X	$3.00 per procedure.
Frame, Temple, or Lens Replacement			X	$2.00 per procedure.
Repair Service			X	$0.50 procedure.

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
HEARING AIDS AND SUPPLIES				
Hearing Aid Purchase			X	$3.00 per service
Hearing Aid Accessories/Repair			X	$1.00 maximum per service.
HOSPITAL SERVICES				
Inpatient - Effective 11/1/83			X	$3.00 per day up to $75.00 per stay.
Outpatient - Effective 1/1/88			X	$3.00 per visit.
INPATIENT STAYS IN INSTITUTIONS FOR MENTAL DISEASES (HOSPITALS)			X	$3.00 per day up to $75.00 per stay.

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
MENTAL HEALTH SERVICES				
Individual and Group Mental Health/AODA Therapy Evaluations Biofeedback			X	Between $0.50 and $3.00 depending on the cost of the service. (No copayment required after 15 hours or $500 of services have been provided per recipient per calendar year.)
Family Therapy and Collateral Interviews			X	$2.00/hour per family per 60 minutes. (Outpatient psychotherapy/AODA and biofeedback services in excess of 15 hours or $500.00 of accumulated services per recipient, per calendar year, are exempt from copayment.)
NURSE PRACTITIONER SERVICES (See Physician Services)				

OFFICIAL

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OCCUPATIONAL THERAPY				
Individual or Group Therapy/Evaluation			X	Between $0.50 and $3.00 depending on the cost of the service. (No co-payment required after 30 hours or $1,500 of services have been provided per recipient per calendar year.)
OPTOMETRIC SERVICES				
Evaluation and Management Visit			X	$1.00-$3.00 per visit.
Ophthalmological Evaluation			X	$1.00-$3.00 per exam.
Low Vision, Diagnostic, Therapy Services			X	$0.50-$3.00 per service.
Contact Lens Services			X	$3.00

OFFICIAL

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
PHYSICAL THERAPY Individual or Group Therapy/Evaluation			X	Between $0.50 and $3.00 depending on the cost of the service. (No co-payment required after 30 hours or $1,500 of services have been paid per recipient per calendar year.)

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
PHYSICIAN AND NURSE PRACTITIONER SERVICES (**Note**: Nurse Practitioners' services are limited to selected procedures and do not encompass all the areas of services listed below.)				
(EVALUATION & MANAGEMENT)				
Office/other Outpatient Visits			X	$1.00-$3.00 per visit.
Emergency Department			X	$1.00 per visit.
Hospital Admissions			X	$1.00-$3.00 per visit.
Hospital Observations			X	$3.00 per visit.
Surgery			X	$3.00 per surgery.
Consultations			X	$1.00-$3.00 per visit.
Home Visits			X	$1.00 per visit.
Preventive Medical Visits			X	$1.00 per visit.
(MEDICINE)				
Biofeedback			X	$0.50 per 60 minutes.

OFFICIAL

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(SURGERY SERVICES)			X	$3.00 per procedure.
(RADIOLOGY SERVICES)			X	$3.00 per service.
(NUCLEAR MEDICINE)			X	$3.00 per service.
(LABORATORY SERVICES)			X	$1.00 per date of service.
(DIAGNOSTIC TESTS)			X	$1.00 per service.
PODIATRY SERVICES				
Home/Office Evaluation and Management Services			X	$1.00-$3.00 per visit.
Laboratory			X	$1.00 per visit.
Radiology			X	$3.00 per service.
Surgery			X	$3.00 per procedure.
Mycotic Conditions and Nails			X	$3.00 per procedure.
Casting/Strapping/Taping			X	$1.00-$3.00 per procedure.
Routine Feet Care			X	$1.00 per visit.
RURAL HEALTH CLINIC SERVICES			X	$2.00 per encounter.

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
SPEECH, HEARING, AND LANGUAGE DISORDER SERVICES Individual or Group Therapy/Evaluation			X	Between $0.50 and $3.00 depending on the cost of the service. (No co-payment required after 30 hours or $1,500 of services have been provided per recipient per calendar year.)
TRANSPORTATION SERVICES Ambulance Base Rate (Non-Emergency Only)			X	$2.00 per trip.